Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Owen Courtney a prisoner at HMP Littlehey on 23 November 2020

A report by the Prisons and Probation Ombudsman

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Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*
Respectful: *we are considerate and courteous*
Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
Fair: *we are honest and act with integrity*

Summary

1. The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

2. We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

3. Mr Owen Courtney died in hospital of skin cancer on 23 November 2020, while a prisoner at HMP Littlehey. He was 78 years old. I offer my condolences to Mr Courtney's family and friends.

4. The clinical reviewer concluded that the clinical care Mr Courtney received at Littlehey was equivalent to that he could have expected to receive in the community. She made no recommendations.

5. We are concerned that the prison did not tell Mr Courtney's next of kin that he was in hospital until 20 November, nine days after he was admitted.

6. This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

Recommendations

- The Governor should ensure that the next of kin of terminally ill prisoners are kept informed and updated on the prisoner's condition, particularly if there is a deterioration in their condition.

The Investigation Process

7. NHS England commissioned an independent clinical reviewer to review Mr Courtney's clinical care at Littlehey.

8. The PPO investigator has investigated non-clinical issues, including Mr Courtney's location, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered.

9. The PPO family liaison officer wrote to Mr Courtney's next of kin, his partner, to explain the investigation. Mr Courtney's partner asked why the prison did not contact her sooner after his admission to hospital. We have addressed this in the report.

10. Mr Courtney's partner received a copy of the initial report. She did not raise any further issues or comment on the factual accuracy of the report.

11. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Previous deaths at HMP Littlehey

12. Mr Courtney was the 18th prisoner to die at Littlehey since November 2018. Of the previous deaths, sixteen were from natural causes and one was self-inflicted. We found no similarities between our findings from our investigation into Mr Courtney's death and our findings from our investigations into the previous deaths.

Key Events

13. On 12 November 2012, Mr Owen Courtney was sentenced to 25 years in prison for sexual offences. On 20 July 2018, he was moved to HMP Littlehey.

14. Mr Courtney had been diagnosed with skin cancer in 2002 and had been treated successfully. In April 2019, the cancer returned and in August, he underwent surgery to remove a lump from under his left armpit. By this time, he also had hypertension (high blood pressure), gout, type 2 diabetes and chronic kidney disease and as a result, could not have immunotherapy.

15. On 23 March 2020, Mr Courtney said he did not want anyone to resuscitate him if his heart or breathing stopped and an Order was completed to that effect.

16. Mr Courtney's cancer spread rapidly to his neck in May and, by September, to his pelvis, chest and lungs. On 21 September, a consultant in palliative medicine told him that the cancer could not be cured. He underwent radiotherapy but continued to deteriorate and he was admitted to hospital for several days in October and again in November.

17. Mr Courtney lived in a single cell on a wing for older prisoners. Due to his illness he had to shield for long periods during the COVID-19 pandemic. He had a carer to help with his daily needs and healthcare staff saw him twice daily to administer medication.

18. On 20 October, the Offender Management Unit at Littlehey started an application for Mr Courtney's early release on compassionate grounds. Unfortunately, Mr Courtney died before a decision about his early release had been reached.

19. On 11 November, Mr Courtney was admitted to hospital. The prison's family liaison officer contacted Mr Courtney's partner on 20 November, after hospital staff contacted the prison to say that Mr Courtney had deteriorated and was expected to die in a few days.

20. Mr Courtney died in hospital on 23 November. There was no post-mortem examination as the Coroner accepted the cause of death provided by a hospital doctor. The doctor gave the cause of death as metastatic melanoma (skin cancer that has spread to other parts of the body).

Non-clinical findings

Contact with Mr Courtney's next of kin

21. Mr Courtney was admitted to hospital on 11 November and remained there until his death on 23 November. The prison's family liaison officer did not tell Mr Courtney's partner that Mr Courtney was in hospital until 20 November. He said this was because Mr Courtney had access to a telephone and could make calls at any time but had chosen not to call his partner.

22. Mr Courtney's partner was upset that she had not been contacted sooner, as by the time she saw Mr Courtney he was semi-conscious.

23. Prison Service Instruction (PSI) 64/2011, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody)*, contains guidance on managing prisoners who are terminally or seriously ill. It says on family engagement with terminally ill prisoners: *'For those prisoners who may not be released before they die, it is important that prisoners are able to maintain closely* [sic] *contact with their family or a nominated person. With the prisoner's agreement, the family should be kept informed and updated on the prisoner's condition particularly if there is deterioration in their condition.'*

24. Mr Courtney's medical record shows that on 11 November, there had been a deterioration in his condition and that he would be sent to hospital. On 13 November, a nurse noted that she had contacted a custodial manager, a contact for the family liaison officers, asking if the family liaison officer could let Mr Courtney's partner know that Mr Courtney had deteriorated and was in hospital. We asked the prison about this, but they said they had no record of these concerns being raised with them. They reiterated that Mr Courtney had access to a telephone that he could have used to call his partner and that when it became apparent that Mr Courtney was too ill to call and was nearing the end of his life, they contacted his partner.

25. We consider that the prison should have contacted Mr Courtney's partner when he was taken to hospital. It was clear from the medical records that Mr Courtney had deteriorated, and yet it took a further nine days before the prison contacted Mr Courtney's partner. We note that the family liaison officer had contacted Mr Courtney's partner on 28 October to tell him he was in hospital on that occasion, so we find it difficult to understand why he did not contact her on 11 November. We consider that the prison failed to follow policy guidance on keeping families informed of a terminally ill prisoner's condition. It was inadequate for staff to rely on Mr Courtney to contact his next of kin himself. We recommend:

The Governor should ensure that the next of kin of terminally ill prisoners are kept informed and updated on the prisoner's condition, particularly if there is a deterioration in their condition.

Louise Richards **May 2021**
Assistant Ombudsman

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